Cancel Form

West Nile Virus Supplemental Form

Kansas Department of Health

Epidemiologic Case History

* indicates required fields

Case Type*
○ *Human Case* ○ *Non Human Case*

Classification*
○ *Confirmed* ○ *Not a Case* ○ *Probable* ○ *Suspect* ○ *Deleted* ○ *Unknown*

Supplemental Form Status
○ *Not Done* ○ *Form Complete* ○ *Form in Progress* ○ *Form Approved* ○ *Form Sent to CDC*

Report Date*
mm/dd/yyyy

Patient Demographic Information

* indicates required fields

Last Name*	First Name*	Middle Name	Name Type*	Age

Age Unit
○ *Days* ○ *Weeks* ○ *Months* ○ *Years*

Date of Birth
mm/dd/yyyy

Race*
(Check all that apply)
☐ *American Indian or Alaska Native* ☐ *Asian* ☐ *Black or African American*
☐ *Native Hawaiian or Other Pacific Islander* ☐ *White* ☐ *Unknown*

Ethnicity*
○ *Hispanic or Latino* ○ *Not Hispanic or Latino* ○ *Unknown*

Sex*
○ *Failure to Report* ○ *Female* ○ *Male* ○ *Other* ○ *Transexual* ○ *Unknown*

Street Address

City	County	State	Zip

Evening Phone
###-###-####

Daytime Phone
###-###-####

Occupation

Person Providing Report

Name of Reporting Facility*

Hospital/Clinic Information

7. Symptoms

Fever? ○ *Yes* ○ *No* ○ *Unknown*	**Stiff Neck?** ○ *Yes* ○ *No* ○ *Unknown*	**Joint Pains?** ○ *Yes* ○ *No* ○ *Unknown*	**Muscle weakness/pain?** ○ *Yes* ○ *No* ○ *Unknown*
Gait/Balance difficulty? ○ *Yes* ○ *No* ○ *Unknown*	**Conjunctivitis?** ○ *Yes* ○ *No* ○ *Unknown*	**Photophobia?** ○ *Yes* ○ *No* ○ *Unknown*	**Rash?** ○ *Yes* ○ *No* ○ *Unknown*
Other eye problems? ○ *Yes* ○ *No* ○ *Unknown*	**If yes, what type:**	**Sleep disturbances?** ○ *Yes* ○ *No* ○ *Unknown*	**Skin hypersensitivity?** ○ *Yes* ○ *No* ○ *Unknown*
Headache? ○ *Yes* ○ *No* ○ *Unknown*	**Fatigue?** ○ *Yes* ○ *No* ○ *Unknown*	**Diarrhea?** ○ *Yes* ○ *No* ○ *Unknown*	**Vomiting?** ○ *Yes* ○ *No* ○ *Unknown*
Nausea? ○ *Yes* ○ *No* ○ *Unknown*	**Depression?** ○ *Yes* ○ *No* ○ *Unknown*	**Memory deficit?** ○ *Yes* ○ *No* ○ *Unknown*	**Seizures?** ○ *Yes* ○ *No* ○ *Unknown*
Confusion? ○ *Yes* ○ *No* ○ *Unknown*	**Disorientation?** ○ *Yes* ○ *No* ○ *Unknown*	**Hallucinations?** ○ *Yes* ○ *No* ○ *Unknown*	**Slurred speech?** ○ *Yes* ○ *No* ○ *Unknown*
Other			

8. Past Medical History

Cancer ○ *Yes* ○ *No* ○ *Unknown*	**Diabetes?** ○ *Yes* ○ *No* ○ *Unknown*	**History of altered mental status** ○ *Yes* ○ *No* ○ *Unknown*	**If Yes, specify:**
Other immunocompromising conditions ○ *Yes* ○ *No* ○ *Unknown*		**If Yes, specify:**	

9. Disposition

What was patient's condition as of the date of this report?

○ *Recovered* ○ *Still in hospital* ○ *Improved, but not to baseline prior to illness*
○ *Discharged - Discharged to:*_____ ○ *Died* ○ *Other*_____

Risk Exposure History

(Symptoms and symptom onset refer to symptoms indicative of WNV, many of which are listed on page 1)

1. Did the patient travel (outside of normal daily travel) during the 3 weeks before illness onset?
○ *Yes* ○ *No* ○ *Unknown*

If yes, where?

Number	Destination	Date of departure	Date of return
		mm/dd/yyyy	mm/dd/yyyy
1			
2			
3 or more			

2. Did the patient spend time outdoors during the 3 weeks prior to illness onset?
○ *Yes* ○ *No* ○ *Unknown*

Explain outdoor activities

3. Did the patient use mosquito repellent containing DEET?
○ *Yes* ○ *No* ○ *Unknown*

If yes, how often?
○ *every time they are outdoors* ○ *most of the time when they are outdoors*
○ *sometimes when they are outdoors* ○ *never when they are outdoors*

Comments:

4. Did the patient use any other form of mosquito repellent?
○ *Yes, what type:*_____ ○ *No* ○ *Unknown*

Risk Exposure History cont.

5. Did the patient do any of the following in the 30 days prior to symptom onset:

Donate blood/blood products ○ *Yes* ○ *No* ○ *Unknown*	**If yes, where did donation take place?**
Receive a blood transfusion ○ *Yes* ○ *No* ○ *Unknown*	**If yes, where did the transfusion take place?**
Donate any organs ○ *Yes* ○ *No* ○ *Unknown*	**If yes, where did donation take place?**
Receive an organ transplant ○ *Yes* ○ *No* ○ *Unknown*	**If yes, where did transplant take place?**

6. Did the patient have any symptoms in the 30 days after:

Blood/products donation? ○ *Yes* ○ *No* ○ *Unknown*	**Date of blood donation** mm/dd/yyyy	**Blood transfusion?** ○ *Yes* ○ *No* ○ *Unknown*	**Date of blood transfusion** mm/dd/yyyy
Organ donation? ○ *Yes* ○ *No* ○ *Unknown*	**Date of organ donation** mm/dd/yyyy	**Organ transplant?** ○ *Yes* ○ *No* ○ *Unknown*	**Date of organ transplant** mm/dd/yyyy

7. (FEMALE PATIENTS ONLY)

Was the patient pregnant at time of symptom onset? ○ *Yes* ○ *No* ○ *Unknown* ○ *N/A*	**If yes, how many months?**	**When is the due date?** mm/dd/yyyy
Was the patient breast feeding at time of symptom onset? ○ *Yes* ○ *No* ○ *Unknown* ○ *N/A*	**If yes, child's name**	**DOB** mm/dd/yyyy
Healthcare provider		

Cancel Form